

Illinois Workers' Compensation Act
820 ILCS 305

§8.2: Medical Fee Schedule

Section 8.2. Fee schedule.

- (a) Except as provided for in subsection (c), for procedures, treatments, or services covered under this Act and rendered or to be rendered on and after February 1, 2006, the maximum allowable payment shall be 90% of the 80th percentile of charges and fees as determined by the Commission utilizing information provided by employers' and insurers' national databases, with a minimum of 12,000,000 Illinois line item charges and fees comprised of health care provider and hospital charges and fees as of August 1, 2004 but not earlier than August 1, 2002. These charges and fees are provider billed amounts and shall not include discounted charges. The 80th percentile is the point on an ordered data set from low to high such that 80% of the cases are below or equal to that point and at most 20% are above or equal to that point. The Commission shall adjust these historical charges and fees as of August 1, 2004 by the Consumer Price Index-U for the period August 1, 2004 through September 30, 2005. The Commission shall establish fee schedules for procedures, treatments, or services for hospital inpatient, hospital outpatient, emergency room and trauma, ambulatory surgical treatment centers, and professional services. These charges and fees shall be designated by geozip or any smaller geographic unit. The data shall in no way identify or tend to identify any patient, employer, or health care provider. As used in this Section, "geozip" means a three-digit zip code based on data similarities, geographical similarities, and frequencies. A geozip does not cross state boundaries. As used in this Section, "three-digit zip code" means a geographic area in which all zip codes have the same first 3 digits. If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment, or service, the Commission may combine data from the geozip with up to 4 other geozips that are demographically and economically similar and exhibit similarities in data and frequencies until the Commission reaches 9 charges or fees for that specific procedure, treatment, or service. In cases where the compiled data contains less than 9 charges or fees for a procedure, treatment, or service, reimbursement shall occur at 76% of charges and fees as determined by the Commission in a manner consistent with the provisions of this paragraph. The Commission has the authority to set the maximum allowable payment to providers of out-of-state procedures, treatments, or services covered under this Act in a manner consistent with this Section. Not later than September 30 in 2006 and each year thereafter, the Commission shall automatically increase or decrease the maximum allowable payment for a procedure, treatment, or service established and in effect on January 1 of that year by the percentage change in the Consumer Price Index-U for the 12 month period ending August 31 of that year. The increase or decrease shall become effective on January 1 of the following year. As used in this Section, "Consumer Price Index-U" means the index published by the Bureau of Labor Statistics of the U.S. Department of Labor, that measures the average change in prices of all goods and services purchased by all urban consumers, U.S. city average, all items, 1982-84=100.
- (b) Notwithstanding the provisions of subsection (a), if the Commission finds that there is a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care, it may change the Consumer Price Index-U increase or decrease for that specific field or specific geographic limitation on access to health care to address that limitation.
- (c) The Commission shall establish by rule a process to review those medical cases or outliers that involve extra-ordinary treatment to determine whether to make an additional adjustment to the maximum payment within a fee schedule for a procedure, treatment, or service.

- (d) When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer directly. The employer shall make payment and providers shall submit bills and records in accordance with the provisions of this Section. All payments to providers for treatment provided pursuant to this Act shall be made within 60 days of receipt of the bills as long as the claim contains substantially all the required data elements necessary to adjudicate the bills. In the case of nonpayment to a provider within 60 days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill or nonpayment to a provider of a portion of such a bill up to the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section, the bill, or portion of the bill, shall incur interest at a rate of 1% per month payable to the provider.

§8.2(e): Balance Billing

- (e) Except as provided in subsections (e-5), (e-10), and (e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the provider regarding participation in a group health plan. If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance. Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury.
- (e-5) If an employer notifies a provider that the employer does not consider the illness or injury to be compensable under this Act, the provider may seek payment of the provider's actual charges from the employee for any procedure, treatment, or service rendered. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.
- (e-10) If an employer notifies a provider that the employer will pay only a portion of a bill for any procedure, treatment, or service rendered in connection with a compensable illness or disease, the provider may seek payment from the employee for the remainder of the amount of the bill up to the lesser of the actual charge, negotiated rate, if applicable, or the payment level set by the Commission in the fee schedule established in this Section. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute. Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.
- (e-15) When there is a dispute over the compensability of or amount of payment for a procedure, treatment, or service, and a case is pending or proceeding before an Arbitrator or the Commission, the provider may mail the employee reminders that the employee will be responsible for payment of any procedure, treatment or service rendered by the provider. The reminders must state that they are not bills, to the extent practicable include itemized information, and state that the employee need not pay until such time as the provider is permitted to resume collection efforts under this Section. The reminders shall not be provided to any credit rating agency. The reminders may request that the employee furnish the provider with information about the proceeding under this Act, such as the file

number, names of parties, and status of the case. If an employee fails to respond to such request for information or fails to furnish the information requested within 90 days of the date of the reminder, the provider is entitled to resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider.

- (e-20) Upon a final award or judgment by an Arbitrator or the Commission, or a settlement agreed to by the employer and the employee, a provider may resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider as well as the interest awarded under subsection (d) of this Section. In the case of a procedure, treatment, or service deemed compensable, the provider shall not require a payment rate, excluding the interest provisions under subsection (d), greater than the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section. Payment for services deemed not covered or not compensable under this Act is the responsibility of the employee unless a provider and employee have agreed otherwise in writing. Services not covered or not compensable under this Act are not subject to the fee schedule in this Section.
 - (f) Nothing in this Act shall prohibit an employer or insurer from contracting with a health care provider or group of health care providers for reimbursement levels for benefits under this Act different from those provided in this Section.
 - (g) On or before January 1, 2010 the Commission shall provide to the Governor and General Assembly a report regarding the implementation of the medical fee schedule and the index used for annual adjustment to that schedule as described in this Section.
- (Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11/16/05.)

§8.3: Medical Fee Advisory Board

Section 8.3. Workers' Compensation Medical Fee Advisory Board. There is created a Workers' Compensation Medical Fee Advisory Board consisting of 9 members appointed by the Governor with the advice and consent of the Senate. Three members of the Advisory Board shall be representative citizens chosen from the employee class, 3 members shall be representative citizens chosen from the employing class, and 3 members shall be representative citizens chosen from the medical provider class. Each member shall serve a 4-year term and shall continue to serve until a successor is appointed. A vacancy on the Advisory Board shall be filled by the Governor for the unexpired term.

Members of the Advisory Board shall receive no compensation for their services but shall be reimbursed for expenses incurred in the performance of their duties by the Commission from appropriations made to the Commission for that purpose.

The Advisory Board shall advise the Commission on establishment of fees for medical services and accessibility of medical treatment.

(Source: P.A. 94-277, eff. 7-20-05.)

§8.7: Utilization Review

Section 8.7. Utilization review programs.

- (a) As used in this Section:

"Utilization review" means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care or nationally recognized peer review guidelines as well as nationally recognized evidence based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review,

independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.

- (b) No person may conduct a utilization review program for workers' compensation services in this State unless once every 2 years the person registers the utilization review program with the Department of Financial and Professional Regulation and certifies compliance with the Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation by URAC for its Workers' Compensation Utilization Management Standards or Health Utilization Management Standards. Nothing in this Act shall be construed to require an employer or insurer or its subcontractors to become URAC accredited.
- (c) In addition, the Secretary of Financial and Professional Regulation may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (b).
- (d) This registration shall include submission of all of the following information regarding utilization review program activities:
 - (1) The name, address, and telephone number of the utilization review programs.
 - (2) The organization and governing structure of the utilization review programs.
 - (3) The number of lives for which utilization review is conducted by each utilization review program.
 - (4) Hours of operation of each utilization review program.
 - (5) Description of the grievance process for each utilization review program.
 - (6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.
 - (7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.
- (e) A utilization review program shall have written procedures to ensure that patient-specific information obtained during the process of utilization review will be:
 - (1) kept confidential in accordance with applicable State and federal laws; and
 - (2) shared only with the employee, the employee's designee, and the employee's health care provider, and those who are authorized by law to receive the information. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.
- (f) If the Department of Financial and Professional Regulation finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with the requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.
- (g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

- (h) The Secretary of Financial and Professional Regulation may by rule establish a registration fee for each person conducting a utilization review program.
- (i) A utilization review will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of health care provider under Section 8(a) or the rights of employers to medical examinations under Section 12.
- (j) When an employer denies payment of or refuses to authorize payment of first aid, medical, surgical, or hospital services under Section 8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program registered under this Section and complies with all other requirements of this Section, then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act and if that denial or refusal to authorize does not comply with a utilization review program registered under this Section and does not comply with all other requirements of this Section, then that will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of whether the employer may be responsible for the payment of additional compensation pursuant to Section 19(k) of this Act.

(Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11/16/05.)